



## **SEHP**

### **The New York State Health Insurance Program's Student Employee Health Plan (SEHP):**

For Graduate Student Employees and their enrolled dependents, COBRA enrollees with SEHP benefits and Young Adult Option enrollees

#### **Call Toll Free 1-877-7-NYSHIP (1-877-769-7447)**

For preauthorization of services or if you have a question about eligibility, providers or claims, call the Plan and choose the program you need.

Medical/Surgical Program representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time and Hospital Program representatives are available Monday through Friday 8 a.m. to 5 p.m. Eastern time. Mental Health and Substance Abuse and Prescription Drug Program representatives are available 24 hours a day, seven days a week. This number is for both The Empire Plan (another NYSHIP plan) and NYSHIP SEHP (except for the NurseLine<sup>SM</sup> option, which is for The Empire Plan only). SEHP dental and vision care plans have separate toll-free numbers (see inside cover).

#### **State of New York Department of Civil Service Employee Benefits Division**

Alfred E. Smith State Office Building  
Albany, NY 12239

web site: <https://www.cs.state.ny.us>

This guide briefly describes the principal NYSHIP SEHP benefits. It is not a complete description and is subject to change.

If you have questions about eligibility, enrollment procedures or the cost of health insurance, contact the Health Benefits Administrator (HBA) on your SUNY campus.

CUNY SEHP enrollees with questions may contact their Health Benefits Administrator (HBA) at the CUNY University Benefits Office.

#### **This publication also includes:**

- The 2011 Empire Plan Flexible Formulary

JANUARY 1, 2011

# **Summary of Benefits**

# Benefit Summary

The NYSHIP Student Employee Health Plan (SEHP) is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan provides medical, dental and vision care benefits.

## What's New

- **Federal Health Care Reform** - Effective January 1, 2011, the federal Patient Protection and Affordable Health Care Act extends health insurance coverage to eligible children up to age 26 and eliminates annual limits for non-network routine health exams and newborn care.
- **Combined Annual Maximum** - There is now a combined annual maximum of \$750,000 for Network and Non-network Services, Basic Medical, Mental Health and Substance Abuse and Prescription Drugs.
- **2011 Empire Plan Flexible Formulary**

## Contact Information

### Hospital Program

Empire BlueCross BlueShield  
New York State Service Center  
P.O. Box 1407, Church Street Station  
New York, NY 10008-1407

### Medical/Surgical Program

UnitedHealthcare  
P.O. Box 1600, Kingston, NY 12402-1600

### Mental Health and Substance Abuse Program

OptumHealth Behavioral Solutions  
P.O. Box 5190, Kingston, NY 12402-5190

### Prescription Drug Program

The Empire Plan Prescription Drug Program  
P.O. Box 5900, Kingston, NY 12402-5900

### Dental Care Plan

GHI, NYS Dental Service  
P.O. Box 12365, Albany, NY 12212-2365

### Vision Care Plan

EyeMed Vision Care  
4000 Luxottica Place, Mason, OH 45040-7111

Teletypewriter (TTY) numbers for callers who use a TTY because of a hearing or speech disability:

<b>Hospital Program</b>	<b>TTY only 1-800-241-6894</b>
<b>Medical/Surgical Program</b>	<b>TTY only 1-888-697-9054</b>
<b>Mental Health and Substance Abuse Program</b>	<b>TTY only 1-800-855-2881</b>
<b>Prescription Drug Program</b>	<b>TTY only 1-800-759-1089</b>

# Quick Reference

**The NYSHIP Student Employee Health Plan (SEHP) is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan has six main parts:**

- (1) Hospital Program**  
insured and administered by Empire BlueCross BlueShield  
Provides coverage for inpatient and outpatient services provided by a hospital or birthing center and for hospice care. Also provides inpatient Benefits Management Program services for preadmission certification of scheduled hospital admissions or within 48 hours after an emergency or urgent admission.  
Services provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.
- (2) Medical/Surgical Program**  
insured and administered by UnitedHealthcare  
Provides coverage for medical services, such as office visits, surgery and diagnostic testing under the network and non-network programs. Coverage for chiropractic care and physical therapy is provided through the Managed Physical Medicine Program. Home care services provided in lieu of hospitalization and diabetic supplies provided by the Home Care Advocacy Program (HCAP). Benefits Management Program services for Prospective Procedure Review for MRI, MRA, CT, PET scan and Nuclear Medicine tests.
- (3) Mental Health and Substance Abuse Program**  
insured by UnitedHealthcare and administered by OptumHealth Behavioral Solution (OptumHealth)  
Provides coverage for inpatient and outpatient mental health and substance abuse services.
- (4) Prescription Drug Program**  
insured and administered by UnitedHealthcare  
UnitedHealthcare utilizes the administrative and mail distribution services of Medco Health Solutions, Inc. (Medco) for services including the retail pharmacy network and mail pharmacy services.  
Provides coverage for prescription drugs, oral contraceptives and diaphragms through network pharmacies, the Medco Pharmacy (mail service) and non-network pharmacies.
- (5) Dental Care Plan**  
administered by GHI 1-800-947-0101  
Provides coverage for dental examinations, cleaning and bitewing X-rays. Also provides discounts on other services.
- (6) Vision Care Plan**  
administered by EyeMed 1-877-226-1412  
Provides coverage for routine eye examinations, eyeglasses or contact lenses.

# 2011 SEHP Copayments at a Glance

## Medical/Surgical Program\*

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### Participating Provider Program

\$10 copayment - office visit, office surgery, urgent care visit, contraceptive drugs and devices (injections, insertions or other physician intervention provided during visit subject to additional copayment), infertility treatment visit, allergy testing, mammography, cervical cytology screening.

\$10 copayment - diagnostic laboratory tests and radiology (not performed during an office visit)

\$10 copayment - ambulatory surgical center (including same day on-site testing and anesthesiology)

### Chiropractic Treatment or Physical Therapy Services (Managed Physical Medicine Program)

\$10 copayment - office visit, up to 15 chiropractic visits per person per calendar year; up to 60 physical therapy visits per diagnosis

\$10 copayment - diagnostic laboratory tests or radiology

\*Note: some medically necessary services are paid in full; others are subject to copayment or a 15-visit per person limit.

## Hospital Program

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\$15 copayment - surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital or an extension clinic (including outpatient surgical locations)

\$25 copayment - emergency room care

\$200 copayment - per admission for covered inpatient hospital stays

\$10 copayment - per visit for medically necessary physical therapy (following related hospitalization or surgery); up to 60 visits

## Mental Health and Substance Abuse Program

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\$10 copayment - visit to network practitioner, for up to 15 visits per person per calendar year (for visits 16 and beyond, non-network outpatient coverage applies)

\$25 copayment - emergency room care

\$200 copayment - per admission for covered network, inpatient mental health stay or inpatient care in a residential treatment center, group home or halfway house

## Prescription Drug Program

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*Up to a 30-day supply from a participating retail pharmacy, mail service or designated specialty pharmacy:*

\$5 copayment - Level 1 or generic drug

\$15 copayment - Level 2 or preferred brand-name drug

\$40 copayment - Level 3 or non-preferred brand-name drug

*31 to 90-day supply through the mail service or designated specialty pharmacy:*

\$5 copayment - Level 1 or generic drug

\$20 copayment - Level 2 or preferred brand-name drug

\$65 copayment - Level 3 or non-preferred brand-name drug

## Dental Care

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\$20 copayment - participating provider visit

\$10 copayment - filling

## Vision Care

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\$10 copayment - routine eye exam

# SEHP Health Insurance Benefit Summary

## Annual Benefit Maximum

For all services combined, including network and non-network hospital, medical, mental health and substance abuse, and prescription drugs, there is one annual maximum of \$750,000.

All services must be medically necessary. "Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carriers, whichever is lower.

## Benefits Management Program



### *for preadmission certification*

#### **If NYSHIP SEHP coverage is primary for you or your covered dependents:**

You must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Hospital Program:

- Before a scheduled (non-emergency) hospital admission
- Before a maternity hospital admission
- Within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission

If you do not call, or if the Hospital Program does not certify the hospitalization, the Plan pays up to 50 percent of the allowable amount after your \$200 copayment. If the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.



### *for Prospective Procedure Review - MRI, MRA, CT, PET scan or Nuclear Medicine tests*

#### **If NYSHIP SEHP coverage is primary for you or your covered dependents:**

You must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program for prior authorization before having a scheduled (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or a Nuclear Medicine test, unless you are having the test as an inpatient in a hospital. If you do not call, your out of pocket cost will be substantially higher. If the test is determined not to be medically necessary, you will be responsible for the entire cost.

# Hospital Program

The Hospital Program pays for covered services provided in an inpatient or outpatient hospital setting or hospice organization. The Medical/Surgical Program provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by the Hospital Program. Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Hospital Program if you have questions about your hospital benefits, coverage or an Explanation of Benefits (EOB) Statement.

## Hospital Inpatient • *Semi-Private Room or Birthing Center*



### *for preadmission certification*

#### **Network Coverage**

**Copayment:** \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

**Coverage Level:** The Plan pays 100 percent of allowable amount after you pay the copayment.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

**Maternity Care:** First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or first 96 hours following a cesarean section are presumed medically necessary and covered at the same copayment and coverage level as other inpatient admissions. If you choose early discharge following delivery, you may request one paid-in-full home care visit.

#### **Non-network Coverage**

**Copayment:** \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

**Coverage Level:** The Plan pays 80 percent of allowable amount after you pay the copayment. You are responsible for the balance.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

**Maternity Care:** Same as network coverage.

## Hospital Outpatient

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### Network Coverage

Surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital (or an extension clinic, including outpatient surgical locations) are subject to one copayment of \$15 per visit. The copayment is waived if you are admitted as an inpatient directly from the outpatient department.

You must have prior authorization for an MRI, MRA, CT, PET scan or a Nuclear Medicine test (see page 3).

\$10 copayment per visit for up to 60 visits for medically necessary physical therapy following a related hospitalization or related inpatient or outpatient surgery.

Emergency room services, including use of the facility for emergency care and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services are subject to one copayment of \$25 per visit. The copayment is waived if you are admitted as an inpatient directly from the emergency room.

Emergency is defined as the sudden onset of symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate care to put the person's life in jeopardy or cause serious impairment of bodily functions.

Paid-in-full benefits for chemotherapy, radiation therapy or dialysis and for preadmission testing and/or presurgical testing prior to an inpatient admission.

### Non-network Coverage

**Outpatient Care:** Same as network coverage, except subject to an annual deductible of \$100 per covered individual. (Not combined with physical therapy deductible.)

**Coinsurance:** The Plan pays 80 percent of allowable amount after you meet the \$100 deductible.

Non-network coverage subject to a separate \$100 deductible for all physical therapy. (Not combined with hospital outpatient deductible.)

**Emergency Care:** Same as network coverage.

Same as network coverage.

## Infertility

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### Network Coverage

The following services provided in the inpatient or outpatient departments of a hospital are covered: artificial/intra-uterine insemination, inpatient and/or outpatient surgical or medical procedures, performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility and associated diagnostic tests and procedures including but not limited to those described in New York State Insurance Law as set forth in Chapter 82 of the Laws of 2002.

### Non-network Coverage

Same as network coverage.

## Hospice Care

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### Network Coverage

Paid-in-full benefit for up to 210 days when provided by an approved hospice program.

### Non-network Coverage

Plan pays up to 100 percent of allowable amount for up to 210 days.

# Medical/Surgical Program

The Medical/Surgical Program pays for covered medical/surgical services by physicians and other covered providers under either network or non-network coverage. Some medically necessary services are paid in full; others are subject to copayment or to a 15-visit per person limit. Note: Any visit you make to your SUNY Campus Student Health Center (which is not a network provider), does not count toward the 15-visit per person limit or network dollar maximum. (This does not apply to CUNY SEHP enrollees). Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program if you have questions about your coverage.

## Network Coverage

Some covered services received from a network provider are paid in full and others are subject to a copayment as described below.

The Plan does not guarantee that participating providers are available in all specialties or geographic locations.

To learn whether a provider participates, check with the provider directly, call the Plan and choose the Medical/Surgical Program or visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online then click on Find a Provider. Always confirm the provider's participation **before** you receive services.

## Non-network Coverage

**Annual Deductible:** \$100 per covered individual.

**Coinsurance:** Plan pays 80 percent of allowable amount for covered services after you meet the annual deductible.

## Inpatient in a Hospital or Birthing Center

### Network Coverage

Covered services received from a network provider while you are an inpatient are paid in full and do not count toward the 15-visit per person limit.

Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, radiology, anesthesiology and pathology.

### Non-network Coverage

Non-network benefits for covered services by a non-network provider.

Same as network coverage.

## Outpatient Department of a Hospital

### Network Coverage

Paid-in-full benefits for covered outpatient services provided in the outpatient department of a hospital by a network provider.

For medical emergency; paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services when these services are not covered by the Hospital Program. Services of other physicians are considered under network coverage or non-network coverage as appropriate.

### Non-network Coverage

Non-network benefits for covered services by a non-network provider.

Same as network coverage.



## Outpatient Department of a Hospital, continued

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### Network Coverage

Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, chemotherapy, anesthesiology, radiology, pathology or dialysis when not covered by Empire BlueCross BlueShield; does not count toward 15-visit per person limit.

Medically necessary physical therapy covered under the Managed Physical Medicine Program when not covered by the Hospital Program.

### Non-network Coverage

Plan pays up to 100 percent of allowable amount.

Non-network coverage under the Managed Physical Medicine Program when not covered by the Hospital Program.

## Doctor's Office Visit, Office Surgery, Laboratory and Radiology

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### Network Coverage

You have network coverage for up to 15 visits per person per calendar year to a participating provider, subject to a \$10 copayment per visit. The copayment includes diagnostic laboratory tests and radiology done during the office visit.

The following types of office visits and services are paid in full and do not count toward the 15-visit per person limit: dialysis, chemotherapy and radiation therapy, well-child care, prenatal and postnatal office visits included in your provider's delivery charge. Prenatal and postnatal office visits that are not included in the delivery charge are subject to a \$10 copayment but do not count toward 15-visit per person limit.

Diagnostic laboratory tests and radiology not performed during an office visit, including interpretation of mammograms and analysis of cervical cytology screening, are covered subject to a \$10 copayment and do not count toward the 15-visit per person limit.

Office-based surgery visits are subject to copayment and count toward the 15-visit per person limit.

Visit to a participating Urgent Care Center are subject to a \$10 copayment and do not count toward the 15-visit per person limit.

You must have prior authorization for an MRI, MRA, CT, PET scan or a Nuclear Medicine test (see page 3).

### Non-network Coverage

Non-network benefits for covered services received from non-participating providers or after the 15th visit to a participating provider.

## Doctor's Office Visit, Office Surgery, Laboratory and Radiology *continued*

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### Network Coverage

**Contraceptive Drugs and Devices:** \$10 copayment for required injections, insertion or other physician intervention provided during an office visit. (This copayment is in addition to your \$10 copayment for the office visit.)

**Infertility Treatment:** \$10 copayment for covered services such as artificial/intrauterine insemination (See Infertility on page 5) provided during an office visit.

**Second Surgical Opinion:** \$10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; counts toward 15-visit per person limit. One paid-in-full in-hospital consultation in each field per confinement.

**Second Opinion for Cancer Diagnosis:** \$10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of course of treatment for cancer.

### Non-network Coverage

**Contraceptive Drugs and Devices:** Same as network coverage, subject to deductible and coinsurance.

**Infertility Treatment:** Same as network coverage, subject to deductible and coinsurance.

**Second Surgical Opinion:** Same as network coverage, subject to deductible and coinsurance.

**Second Opinion for Cancer Diagnosis:** Same as network coverage.

## Routine Health Exams

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### Network Coverage

Same as non-network coverage.

### Non-network Coverage

Routine Physicals are covered once every two years for the active employee under age 40, or annually for the active employee over age 40. The Plan pays 80 percent of the allowable amount for covered services. There is no coverage for routine health exams for a spouse or domestic partner. This benefit is not subject to copayment or 15-visit per person limit or deductible.

## Allergy Care

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### Network Coverage

Office visits are covered subject to a \$10 copayment and count toward 15-visit per person limit. No separate copayment for basic skin tests done during an office visit. Tests provided on different date or different location require a separate \$10 copayment, but do not count toward 15-visit per person limit. Allergy injections and extracts are not covered; see *Exclusions*, page 18.

### Non-network Coverage

Not covered

## Routine Well-Child Care

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### Network Coverage

Paid-in-full benefit for children up to age 19 including examinations and immunizations administered pursuant to pediatric guidelines. Well-child care visits do not count toward the 15-visit per person limit.

### Non-network Coverage

Plan pays 100 percent of allowable amount. This benefit is not subject to deductible or coinsurance.

## Mammograms and Cervical Cytology Screening

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### Network Coverage

\$10 copayment for mammography received from a network provider following recommended guidelines; \$10 copayment for cervical cytology screening. (Also see Hospital Outpatient, page 5.)

### Non-network Coverage

Plan pays 80 percent of allowable amount after you meet the annual deductible.

## Pregnancy Termination

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### Network Coverage

Paid-in-full benefit; does not count toward 15-visit per person limit.

### Non-network Coverage

Plan pays 80 percent of allowable amount after you meet the annual deductible.

## Ambulatory Surgical Center

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### Network Coverage

\$10 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a participating surgical center.

### Non-network Coverage

Non-network benefits for covered services provided by non-participating surgical centers.

## Ambulance Service

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### Network Coverage

Plan pays for local commercial ambulance charges for emergency transportation, subject to a \$15 copayment.

**Emergency Ambulance Transportation** is covered when the service is provided by a licensed ambulance service to the nearest hospital where emergency care can be performed and ambulance transportation is required because of an emergency condition.

### Non-network Coverage

Same as Network Coverage.

**Emergency Ambulance Transportation** is covered the same as network coverage. This benefit is not subject to deductible or coinsurance.

## Enteral Formulas; Modified Solid Food Products

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### Network Coverage

Same as non-network coverage.

### Non-network Coverage

For prescribed enteral formulas, Plan pays up to 80 percent of allowable amount after you meet the annual deductible. For certain prescribed modified solid food products, Plan pays up to 80 percent of allowable amount after you meet the annual deductible, up to a total maximum reimbursement of \$2,500 per covered person per calendar year.

## Managed Physical Medicine Program *administered by Managed Physical Network (MPN)*

### Chiropractic Treatment and Physical Therapy

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#### **Network Coverage** *(When you use MPN)*

You pay a \$10 copayment for each office visit to an MPN provider. You pay an additional \$10 copayment for related radiology and diagnostic laboratory services billed by the MPN provider.

**Chiropractic Treatment:** Up to 15 visits per person per calendar year.

**Physical Therapy:** Up to 60 visits per diagnosis, if determined by MPN to be medically necessary.

Access to network benefits is guaranteed for chiropractic treatment and physical therapy. If there is no network provider in your area, call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program.

***Program requirements apply even if Medicare or another health insurance plan is primary.***

#### **Non-network Coverage** *(When you don't use MPN)*

**Annual Deductible:** \$100 per covered individual. This deductible is separate from other plan deductibles.

**Coinsurance:** Plan pays up to 80 percent of allowable amount after you meet the annual deductible. Non-network benefits for covered services received from non-network providers, or after the 15<sup>th</sup> chiropractic visit per year, or after the 60<sup>th</sup> physical therapy visit per diagnosis, by a network provider.

## Home Care Advocacy Program (HCAP)

### Home Care Services in Lieu of Hospitalization and Diabetic Equipment/Supplies

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#### ***for prior authorization***

#### **Network Coverage** *(When you use HCAP)*

Home care services provided in lieu of hospitalization are paid in full for 365 visits. To receive this benefit, you must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program's Home Care Advocacy Program (HCAP) for prior authorization.

Diabetic equipment and supplies, including insulin pumps and Medijectors are paid in full. To receive diabetic equipment and supplies, (except insulin pumps and Medijectors) call The Empire Plan Diabetic Supplies Pharmacy at **1-888-306-7337**. For insulin pumps and Medijectors you must use a network provider. Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program's HCAP for prior authorization.

***Important: If Medicare is your primary coverage, and you do not use a Medicare contracted provider, your benefits will be further reduced.***

***Program requirements apply even if Medicare or another health insurance plan is primary.***

#### **Non-network Coverage** *(When you don't use HCAP)*

Home care services are not covered unless precertified. If precertified, Plan pays 80 percent of allowable amount after you meet the annual deductible.

Diabetic equipment and supplies are covered up to 100 percent of allowable amount; not subject to deductible and coinsurance.

# Mental Health and Substance Abuse Program



## **for prior authorization**

**Precertification required. Call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program before seeking any treatment for mental health or substance abuse, including alcoholism.** The Mental Health and Substance Abuse Program's Clinical Referral Line is available 24 hours a day, every day of the year. By following the Program requirements for network coverage, you will receive the highest level of benefits. Access to network benefits is guaranteed.

In an emergency, the Mental Health and Substance Abuse Program will either arrange for an appropriate provider to call you back (usually within 30 minutes) or direct you to an appropriate facility for treatment. In a life-threatening situation, go to the emergency room. If you are admitted as an inpatient, you or someone acting on your behalf should call the Mental Health and Substance Abuse Program within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

**Program requirements apply even if Medicare or another health insurance plan is primary.**

Only treatment determined medically necessary by OptumHealth is covered.

*If you are in treatment for mental health or alcohol/substance abuse at the time your NYSHIP SEHP coverage begins, please contact OptumHealth for help in making the transition to your NYSHIP coverage.*

## Facility Charges

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### Network Coverage

**Inpatient care in an Approved General Acute or Psychiatric Hospital or Clinic: inpatient and partial hospitalization, intensive outpatient and day treatment programs, 23 hour extended and 72 hour crisis beds.**

**Copayment:** \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays up to 100 percent of the network allowance after you pay the copayment.

**Inpatient care in a Residential Treatment Center, Group Home or Halfway House.** Coverage for up to 30 days per person per year in an approved facility. \$200 copayment per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: Plan pays up to 80 percent of the network allowance after the copayment. You pay the remaining balance.

**Hospital Emergency Room:** You pay a \$25 copayment (waived if you are admitted as an inpatient directly from the emergency room).

### Practitioner Visits

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#### Network Coverage

Network coverage for up to 15 visits per person per calendar year to a network practitioner, subject to a \$10 copayment per visit. You pay the copayment. For visit 16 and beyond, non-network outpatient coverage applies.

### Non-network Coverage

**Inpatient care in an Approved General Acute or Psychiatric Hospital or Clinic: inpatient and partial hospitalization, intensive outpatient and day treatment programs, 23 hour extended and 72 hour crisis beds.**

**Copayment:** \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays 80 percent of the allowable amount after you pay the copayment. You pay the remaining balance.

**Inpatient care in a Residential Treatment Center, Group Home or Halfway House.** Not a covered benefit.

**Hospital Emergency Room:** Same as network benefits.

#### Non-network Coverage

Non-network benefits for covered services received from non-network practitioners or after the 15<sup>th</sup> visit to a network practitioner. Annual deductible: \$100 per covered individual. Plan pays 80 percent of OptumHealth's allowable amount for covered services after the deductible. You pay the deductible and the remaining balance. The annual deductible is separate from the medical deductible.

# Prescription Drug Program

## Benefit Maximum

Prescription drug coverage is included in the combined \$750,000 annual benefit maximum.

## Copayments

You have the following copayments for drugs purchased from a participating pharmacy or through the mail service pharmacy.

<b>Up to a 30-day supply from a participating retail pharmacy, mail service pharmacy or designated specialty pharmacy</b>	<b>31- to 90-day supply through the mail service pharmacy or designated specialty pharmacy</b>
Level 1 or Generic Drug.....\$5	Level 1 or Generic Drug .....\$5
Level 2 or Preferred Brand-name Drug.....\$15	Level 2 or Preferred Brand-name Drug .....\$20
Level 3 or Non-preferred Brand-name Drug .....\$40	Level 3 or Non-preferred Brand-name Drug .....\$65

When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 non-preferred brand-name copayment plus the difference in cost between the brand-name drug and the generic (ancillary charge), not to exceed the full retail cost of the drug. Certain drugs are excluded from this requirement. You pay only the applicable copayment for these brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol, and Tegretol XR. You have coverage for prescriptions for more than a 30-day supply through the mail service pharmacy or designated specialty pharmacy. Oral contraceptives are covered as brand-name or generic. Prescriptions may be refilled for up to one year.

**Note: At certain SUNY Campus Student Health Centers, SUNY SEHP enrollees and/or their dependents are able to fill prescriptions for a \$7 copayment for up to a 30-day supply. See your Health Benefits Administrator for more information. (This does not apply to CUNY SEHP enrollees.)**

## Mail Service Pharmacy

You may fill your prescription by mail through Medco Pharmacy by using the mail service envelope. For envelopes and refill orders, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Prescription Drug Program. To refill a prescription on file with Medco Pharmacy, you may order by phone or download order forms online at the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online. Click on Find a Provider and scroll down to Medco Pharmacy Mail-Order Form.

## Non-Participating Pharmacy

If you do not use your benefit card at a participating or non-participating pharmacy and pay the full retail cost of your prescription, you must submit a claim for reimbursement to Medco, P.O. Box 14711, Lexington, KY, 40512. If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the program would reimburse a participating pharmacy for that prescription. If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the program would reimburse a participating pharmacy for filling the prescription with that drug's generic equivalent. In most cases, you will not be reimbursed the total amount you paid for the prescription.

## **Specialty Pharmacy Program**

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The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services including disease and drug education, compliance management, side-effect management and safety management. Most specialty drugs will only be covered when dispensed by The Empire Plan's designated specialty pharmacy, Accredo, a subsidiary of Medco. Also included in this Program are expedited, scheduled delivery of your medications at no additional charge, refill reminder calls and all necessary supplies such as needles and syringes applicable to the medication.

For a complete list of specialty medications included in the Specialty Pharmacy Program, visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online. Click on Find a Provider, scroll down to Prescription Drug Program and then select Specialty Drug Program to see a complete list of specialty medications included in the Specialty Pharmacy Program. Specialty medications must be ordered through the Specialty Pharmacy Program using the Medco Pharmacy Mail-Order Form. Prior authorization is required for some specialty medications.

To request refills or to speak to a specialty-trained pharmacist or nurse regarding the Program, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)**, choose Option 4 for the Prescription Drug Program, and ask to speak with Accredo, 24 hours a day, seven days a week.

## **Prior Authorization Required**

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***You must have prior authorization for the following drugs, including generic equivalents:***

- |             |                    |            |              |                     |
|-------------|--------------------|------------|--------------|---------------------|
| • Actemra   | • Dysport          | • Intron-A | • Peg-Intron | • Synagis           |
| • Adcirca   | • Enbrel           | • Iplex    | • Provigil   | • Tracleer          |
| • Amevive   | • Epogen/Procrit   | • Kineret  | • Rebif      | • Tysabri           |
| • Ampyra    | • Flolan           | • Kuvan    | • Remicade   | • Tyvaso            |
| • Aranesp   | • Forteo           | • Lamisil  | • Remodulin  | • Ventavis          |
| • Avonex    | • Growth Hormones  | • Letairis | • Revatio    | • Weight Loss Drugs |
| • Betaseron | • Humira           | • Myobloc  | • Ribavirin  | • Xolair            |
| • Botox     | • Immune Globulins | • Nuvigil  | • Simponi    | • Xyrem             |
| • Cimzia    | • Increlex         | • Orencia  | • Sporanox   |                     |
| • Copaxone  | • Infergen         | • Pegasys  | • Stelara    |                     |

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds \$100 will also require prior authorization under this Program. The above list of drugs is subject to change as drugs are approved by the Food and Drug Administration and introduced into the market. For the most current Empire Plan drug list, prior authorization requirements, or the current list of drugs requiring authorization, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Prescription Drug Program. Or, go to the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to NYSHIP Online. Select Find a Provider and scroll to Prescription Drug Program and click The Empire Plan: Drugs that Require Prior Authorization.



## Half Tablet Program

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Effective January 1, 2011, the Half Tablet Program can dramatically lower your costs on select medications that you take on a regular basis. To participate in the Program, your doctor must write a new prescription for twice the dosage and half the quantity. Then when you fill the prescription, you will automatically pay only half your usual copayment. Split each tablet and take half to get your usual dosage at half the cost. To see a list of medications available under this program, go to the New York State Department of Civil Service web site at <http://www.cs.state.ny.us> and select Benefit Programs. Follow the prompts to access NYSHIP Online and choose Find a Provider. Scroll to the Prescription Drug Program links and click on Empire Plan Half Tablet Program. The Empire Plan will provide participants with one free tablet splitter by mail upon request.

## Flexible Formulary

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The Empire Plan Prescription Drug Program has a flexible formulary for prescription drugs. The Empire Plan Flexible Formulary drug list is designed to provide enrollees and the Plan with the best value in prescription drug spending. This is accomplished by:

- excluding coverage for a small number of drugs;
- placing brand-name drugs that provide the best value to the Plan on the Flexible Formulary drug list; and
- applying the highest copayment to non-preferred brand-name drugs that provide no clinical advantage over generic or preferred brand-name drug alternatives.

***An excluded drug is not subject to any type of appeal or coverage review, including a medical necessity appeal.***

## 2011 Flexible Formulary Changes

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Certain drugs have been added to the list of drugs excluded from coverage under the 2011 Flexible Formulary. A list of accepted alternatives to these excluded drugs, along with a complete list of all excluded drugs, is available online. Visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online. Click on Using Your Benefits and then 2011 Empire Plan Flexible Formulary.

New prescription drugs may be subject to exclusion when they first become available on the market. Check the web site for current information regarding exclusions of newly launched prescription drugs. Coverage for prescription drugs excluded under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under the Empire Plan Flexible Formulary.

### Newly Excluded drugs:

- |             |                |  |            |                  |
|-------------|----------------|--|------------|------------------|
| • Acuvail   | • Epiduo       | • Naprelan   | • Ryzolt   | • Zegrid Capsule |
| • Aplenzin  | • Extavia      | • Neobenz Micro  | • Terbinex | • Ziana          |
| • BenzEfoam | • Metozolv ODT | • Omeprazole/sodium bicarbonate capsule (generic Zegrid) | • Triaz    | • Zipsor         |
| • Edluar    | • Momexin Kit  |  | • Twynsta  |                  |

# SEHP Dental Care Benefit Summary

## Dental Program

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Each visit is subject to a \$20 copayment, up to two visits per 12-month period when you visit a participating provider in the SEHP dental program for covered services.

### Covered Services

- Initial examination, including charting
- Periodic examination
- Cleaning
- Bitewing X-rays, maximum four X-rays per year

Up to two fillings per 12-month period are covered subject to a \$10 copayment per filling when you visit a participating provider in the SEHP dental program.

**Participating Provider:** To locate a participating provider in the SEHP dental program, you can link to the GHI web site by accessing <https://www.cs.state.ny.us>. From the home page, click on Other Benefits and then choose Dental, or call **1-800-947-0101**.

## GHI's Discounted Dental Access Program

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When you enroll in the SEHP dental program you are automatically enrolled in GHI's Discounted Dental Access Program. If you utilize a provider who participates in the GHI Discounted Dental Access Program (and receive services other than the covered services above), you are required to pay the provider directly for all care received, and your liability is reduced to a prearranged discounted access rate. You are not subject to precertification or eligibility verification when you utilize the discounted program.

**Participating Provider:** To locate a participating provider in the GHI Discounted Dental Access Program, please call GHI's Dedicated Customer Service Center at **1-800-947-0101** for a list or a CD-ROM identifying GHI Discounted Dental Access Program participating providers.

## Administration

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For **Eligibility** questions, please contact the Health Benefits Administrator (HBA) on your campus.

For **Customer Service**, please contact GHI's Dedicated Customer Services Center at **1-800-947-0101** after you have enrolled.

**Correspondence:** Please direct your correspondence to:

GHI, Attn: NYS Dental Customer Service, P.O. Box 12365, Albany, NY 12212-2365

Please be sure to include your identification number on all correspondence.

**ID Card:** If you go to a provider who participates in the SEHP dental program and/or the GHI Discounted Dental Access Program, present your GHI identification card before you receive services.

# SEHP Vision Care Benefit Summary

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## Network Benefits

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A routine eye examination (subject to a \$10 copayment) is covered once in any 24-month period (based on your last date of service).

A limited selection of frames and lenses or daily wear, disposable or planned replacement contact lenses offered by a participating provider at the time and place of an eye exam will be paid in full. This benefit is available only once in any 24-month period. There is no coverage for services received from a non-participating provider.

## To Confirm Eligibility or Locate a Network Provider

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Contact EyeMed, the plan administrator, at **1-877-226-1412** or link to their web site by accessing <https://www.cs.state.ny.us>. Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. From the home page, click on Other Benefits and then choose Vision.

## To Receive Services from a Network Provider

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- Contact the network provider and schedule an appointment.
- Identify yourself as covered under the SEHP vision care program available through the NYS Vision Plan, which is administered by EyeMed.
- Give the provider your name and date of birth, or member ID number.

The provider will confirm your eligibility and obtain an authorization to provide services. At the time of your appointment, be sure to pay the provider your \$10 eye examination copayment.

# Exclusions

## Services not covered under the SEHP include, but are not limited to, the following:

- Combined expenses in excess of \$750,000 for network and non-network hospital, medical, mental health and substance abuse, and prescription drugs;
- Care that is not medically necessary;
- Experimental or investigative procedures;
- Custodial care;
- Cosmetic surgery;
- Routine foot care;
- Sex change;
- Durable medical equipment and supplies unless provided under the Home Care Advocacy Program (HCAP);
- Prosthetics (except breast prostheses, which are paid in full);
- Orthotics;
- TMJ treatment (except when caused by a medical condition);
- Hearing aids;
- Weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity);
- Adult immunizations (except as part of a covered routine physical);
- Skilled nursing facility care including rehabilitation;
- Allergy extracts and injections;
- Inpatient alcohol and substance abuse rehabilitation;
- Psychological testing and evaluation and outpatient psychiatric second opinion;
- Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease;
- Reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intra-uterine insemination and other services for which coverage is mandated by New York State Insurance Law); cloning;
- Cardiac rehabilitation;
- Occupational therapy;
- Speech therapy.

# Benefits On the Web

You'll find NYSHIP Online, the Employee Benefits Division home page, on the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. Click on Benefit Programs and follow the prompts to NYSHIP Online.

On your first visit, you will be asked what group and benefit plan you have. Thereafter, you will not be prompted to enter this information if you have your cookies enabled. Cookies are simple text files stored on your web browser to provide a way to identify and distinguish the users of this site. If enabled, cookies will customize your visit to the site and group-specific pages will then display each time you visit unless you select Change Your Group on a toolbar near the top left of the page.

Without enabling cookies, when you select your group and health benefits plan to view your group-specific health insurance benefits, you will be required to reselect your group and benefits plan each time you navigate the health benefits section of the web site or revisit the site from the same computer at another time.

NYSHIP Online is a complete resource for your health insurance benefits, including up-to-date publications. You'll also find links to select Empire Plan carrier web sites. These web sites include the most current list of providers. You can search by location, specialty or name. Announcements, an event calendar, prescription drug information and handy contact information are only a click or two away.

# Federal Health Care Reform

## Grandfathered Health Plans

Under the Patient Protection and Affordable Care Act, a grandfathered health plan is permitted to preserve certain basic health coverage that was already in effect when the Act was signed into law on March 23, 2010. Being a grandfathered health plan means that the plan may delay implementation of certain features of health care reform that apply to other non-grandfathered health plans. For example, the requirement for the provision of preventive health services without any cost sharing does not need to be included under a health care plan until the plan is no longer grandfathered. However, grandfathered health plans must comply with certain other consumer protections in the Act such as the elimination of lifetime limits on certain benefits. The benefit package provided to your group is a grandfathered plan.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan status can be directed to the New York State Department of Civil Service Employee Benefits Division, Alfred E. Smith State Office Building, Albany, NY 12239. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

The *NYSHIP SEHP Summary of Benefits* is published by the Employee Benefits Division of the State of New York Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits. If you have questions, call 1-877-7-NYSHIP (1-877-769-7447) and choose the program you need.



New York State Department of Civil Service  
Employee Benefits Division, Albany, NY 12239

518-457-5754 (Albany area) 1-800-833-4344  
(U.S., Canada, Puerto Rico, Virgin Islands)  
<https://www.cs.state.ny.us>

*This document provides a brief look at SEHP medical, dental and vision care benefits. If you have any questions or need claim forms, call the appropriate benefits carrier.*

State of New York  
Department of Civil Service  
Employee Benefits Division  
P.O. Box 1068  
Schenectady, NY 12301-1068  
<https://www.cs.state.ny.us>

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Information for the Enrollee, Enrolled Spouse/  
Domestic Partner and Other Enrolled Dependents

SEHP Summary of Benefits – January 2011



**Please do not send mail  
or correspondence to  
the return address  
above. See boxed  
address on page 19.**

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It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the Department of Civil Service web site (<https://www.cs.state.ny.us>). Check the web site for timely information that meets universal accessibility standards adopted by New York State for NYS agency web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

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## Notice of Access to Women's Health Services

This notice is provided in accordance with the NYS Women's Health and Wellness Act. The Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. The Plan covers services required as a result of such examinations. The Plan covers services required as a result of an acute gynecologic condition. The Plan covers all care related to pregnancy. Benefits for these services are paid according to the terms of network or non-network coverage.

**Benefits Management Program requirements apply. See page 3.**

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## Annual Notice of Mastectomy and Reconstructive Surgery Benefits

The Plan covers inpatient hospital care for lymph node dissection, lumpectomy and mastectomy for treatment of breast cancer for as long as the physician and patient determine hospitalization is medically necessary. The Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery of the other breast to produce a symmetrical appearance. The Plan also covers treatment for complications of mastectomy, including lymphedema and breast prostheses.

**Benefits Management Program requirements apply. See page 3.**